COMMUNITY CARE LICENSING DIVISION

"Promoting Healthy, Safe and Supportive Community Care"

TECHNICAL SUPPORT PROGRAM

Self-Assessment Guide

RESIDENTIAL CARE FACILITY FOR THE ELDERLY PREADMISSION QUESTIONNAIRE

CDSS

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

TECHNICAL SUPPORT PROGRAM

RESIDENTIAL CARE FACILITY FOR THE ELDERLY

PREADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist licensees in identifying specific medical and behavioral issues that may affect the placement of and/or services to be provided to prospective residents of Residential Care Facilities for the Elderly (RCFE). The questions on this form should be reviewed with the applicant's responsible party prior to admission to the facility. If the answer to any of the questions on this list is yes; the licensee should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs.

The information on this form supplements the Preplacement Appraisal Information form (LIC 603), but does not replace it. While the information gathered from this form should assist licensees in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date:_____

Applicants Name:_____DOB:_____

Current Residence
own home_____ with family_____ Board & Care_____ SNF_____ Hospital_____

Reason for Placement in RCFE:_____
_____
_____
_____

Applicants Physician:_____

A. LEVEL OF CARE ASSESSMENT

YES	**NO**	
		1. Oxygen Administration
☐	☐	Does the applicant use oxygen? If yes, explain_____ _____ _____ _____(See 87703)
☐	☐	Does the applicant need assistance? If yes, explain_____ _____ _____ _____(Exception required. See 87703)
☐	☐	Does the applicant use liquid oxygen? If yes, explain_____ _____ _____(Exception required. See 87701(a)(14) policy)

LEVEL OF CARE ASSESSMENT (continued)

YES	NO	
		2. Intermittent Positive Pressure Breathing (IPPB) Machine
☐	☐	Does the applicant use an IPPB? If yes, explain_____ _____ _____ _____ _____(See 87704)
☐	☐	Does the applicant need assistance? If yes, explain_____ _____ _____(Exception required. See 87704)
		3. Colostomy/Ileostomy
☐	☐	Does the applicant have a colostomy or ileostomy? If yes, explain____ _____ _____ _____(See 87705)
☐	☐	Does the applicant need assistance? If yes, explain_____ _____ _____ _____(Exception required. See 87705)
		4. Enema/Suppository/Fecal Impaction Removal
☐	☐	Does the applicant need enemas, suppositories or fecal impaction removal? If yes, explain_____ _____ _____ _____(See 87706)
☐	☐	Does the applicant need assistance? If yes, explain_____ _____ _____ _____(See 87706) (Procedures must be performed by an Appropriately Skilled Professional [ASP])
		5. Catheter Care
☐	☐	Does the applicant have a catheter? If yes, explain_____ _____ _____(See 87707)
☐	☐	Does the applicant need assistance? If yes, explain_____ _____ _____ _____(Exception may be required. See 87707)

LEVEL OF CARE ASSESSMENT (continued)

YES	NO	
☐	☐	6. Bowel and Bladder Incontinence Is the applicant incontinent of bowel or bladder? If yes, explain _____ _____ _____ _____(See 87708)
		7. Contractures
☐	☐	Does the applicant have contractures? If yes, explain_____ _____ _____ _____(See 87709)
☐	☐	Does the applicant need assistance? If yes, explain_____ _____ _____ _____(Exception required. See 87709)
☐	☐	Do the contractures severely affect the applicant's ability to function? (If yes, not allowed in RCFE)
		8. Diabetes
☐	☐	Does the applicant have diabetes? If yes, explain_____ _____ _____ _____(See 87710)
☐	☐	Does the applicant require assistance with performing or reading glucose tests, drawing up injectable medications or administering injections? If yes, explain_____ _____ _____ (Procedures must be performed by an ASP. See 87710)
		9. Injections
☐	☐	Does the applicant need any injections? If yes, explain_____ _____ _____(See 87711)
☐	☐	Does the applicant need assistance with drawing up and administering the injections? If yes, explain_____ _____ _____ (Procedures must be performed by an ASP. See 87710)
		10. Healing Wounds
☐	☐	Does the applicant have any healing wounds? If yes, explain_____ _____ _____ _____(Exception required. See 87713)

LEVEL OF CARE ASSESSMENT (continued)

YES	NO	
☐	☐	Does the applicant have stage 1 or 2 dermal ulcers (bedsores)? If yes, explain_____ _____ _____ _____(Exception required. See 87713)
☐	☐	Does the applicant have stage 3 or 4 dermal ulcers? (If yes, not allowed in RCFE)
		11. PRN Medications
☐	☐	Does the applicant take any prescription or over the counter PRN (as needed) medications? If yes, please list_____ _____ _____ _____(See 87715)
☐	☐	Does the applicant need assistance in determining the need for a dose of the PRN? If yes explain _____ _____ _____ _____(Allowed only if physician is contacted before each dose is given. See 87715)
		12. Bedridden/Bedfast
☐	☐	Is the applicant bedridden/bedfast? If yes, explain_____ _____ _____ _____ _____(See 87582)
☐	☐	Is the condition temporary (less than 14 days)? If yes, explain _____ _____ _____ _____ _____ _____(See 87582)
☐	☐	Is the condition temporary (more than 14 days)? If yes, explain _____ _____ _____ _____ _____(Exception required. See 87582)
☐	☐	Is the condition permanent? (If yes, not allowed in an RCFE)

LEVEL OF CARE ASSESSMENT (continued)

YES	NO	
		13. Gastrostomy
☐	☐	Does the applicant have a gastrostomy? (If yes, not allowed in an RCFE. See 87701)
		14. Naso Gastric (NG) Tubes
☐	☐	Does the applicant have NG tubes? (If yes, not allowed in an RCFE. See 87701)
		15. Staph Infection
☐	☐	Does the applicant have a staph or other serious infection? (If yes, not allowed in an RCFE. See 87701)
		16. Total Care
☐	☐	Does the applicant need total care (assistance with ALL activities of daily living - eating, bathing, dressing, grooming, AND toileting)? (If yes, not allowed in an RCFE. See 87701)
		17. Tracheostomies
☐	☐	Does the applicant have a tracheostomy? (If yes, not allowed in an RCFE. See 87701)

B. PERSONS WITH DEMENTIA

YES	NO	
☐	☐	Does the applicant have Dementia?
☐	☐	Is the applicant ambulatory, as determined by a physician? If yes, explain_____ _____ _____(See 87724)
☐	☐	Is the applicant nonambulatory, as determined by a physician? If yes, explain_____ _____ _____ _____(Exception required. See 87724)

C. BEHAVIORAL ASSESSMENT

Does the applicant have a history of any of the following behaviors?

YES	NO	
☐	☐	1. Physical assaultiveness
☐	☐	2. Verbal assaultiveness
☐	☐	3. Wandering
☐	☐	4. Sexual assaultiveness, molestation or inappropriate sexual activity
☐	☐	5. Disruptiveness (screaming, throwing things, argumentative)
☐	☐	6. Property destruction
☐	☐	7. Careless disposal of smoking materials
☐	☐	8. Stealing

BEHAVIORAL ASSESSMENT (continued)

If the answer to any of the above is yes, describe the behavior:_____
_____
_____
_____
_____
_____

Frequency and duration of the behavior(s):_____
_____
_____

Approximate date of last occurrence:_____

What seems to trigger the behavior:_____
_____
_____
_____
_____

Strategies to deal with the behavior:_____
_____
_____
_____

Does the applicant have a history of any of the following behaviors?

YES	NO	
☐	☐	1. Refusal to take medication
☐	☐	2. Refusal to get medical attention
☐	☐	3. Refusal to bathe or wear clean clothing
☐	☐	4. Non-compliance with house rules
☐	☐	5. Self-abuse
☐	☐	6. Suicide attempts or suicidal thoughts
☐	☐	7. Depression
☐	☐	8. Alcohol or drug abuse

If the answer to any of the above is yes, describe the behavior:_____
_____
_____
_____
_____
_____

Frequency and duration of the behavior(s):_____
_____
_____

Approximate date of last occurrence:_____

What seems to trigger the behavior:_____
_____
_____
_____

BEHAVIORAL ASSESSMENT (continued)

Strategies to deal with the behavior:_____
_____
_____

D. MISCELLANEOUS

YES	NO	
☐	☐	1. Does the applicant currently use any prescription or over the counter medications? If yes, please list_____ _____ _____ _____
☐	☐	2. Does the applicant have any emergency medication that must be kept at bedside? If yes, please list:_____ _____
☐	☐	3. Will the applicant be willing to have all of his/her medications, including over the counter medications, centrally stored?
		4. Does the applicant use any of the following devices?
☐	☐	Glasses
☐	☐	Dentures
☐	☐	Hearing Aid
☐	☐	Other _____
		5. Does the applicant need assistance with any of the following?
☐	☐	Eating. If yes, explain_____ _____ _____
☐	☐	Bathing. If yes, explain _____ _____ _____
☐	☐	Dressing. If yes, explain_____ _____ _____
☐	☐	Grooming. If yes, explain_____ _____ _____
☐	☐	Toileting. If yes, explain_____ _____ _____
		6. Does the applicant use any of the following?
☐	☐	Cane. If yes, explain _____ _____

MISCELLANEOUS (continued)

☐ ☐ Crutch. If yes, explain_____
_____
_____

☐ ☐ Walker. If yes, explain_____
_____
_____

☐ ☐ Wheelchair. If yes, explain_____
_____
_____

☐ ☐ 7. Does the applicant have any paralysis? If yes, explain (site, degree, assistance needed)_____
_____
_____

☐ ☐ 8. Is the applicant unable to transfer? If yes, describe assistance needed_____
_____
_____

☐ ☐ 9. Does the applicant require a special diet? If yes, explain_____
_____
_____

☐ ☐ 10. Does the applicant have any skin condition or history of skin breakdown? If yes, explain_____
_____
_____

☐ ☐ 11. Will the applicant require transportation to any appointments or events other than routine local medical appointments? If so, where and how often?_____
_____
_____

Applicant/Responsible Person:_____
(Signature)

Date:_____

Facility Representative:_____
(Signature)

Date:_____